New Jersey Department of Health and Senior Services

APPLICATION FOR MINI-GRANT FUNDS ($25,000 or Less)

(TYPE OR PRINT ALL DATA)

FOR STATE USE
Spending Plan No. _____
Funding Authorization No.(s) _____ _____ _____

1. Name of Applicant

2. Street Address | City | County | State | Zip Code

3. Name and Title of Fiscal Contact | Telephone No.

Street Address | City | County | State | Zip Code

4. Name of Attorney for Agency | Telephone No.

5. Name and Title of Principal Contact | Telephone No.

6. Employer ID No.

7. Certificate of Need Project (if applicable) ☐ PENDING ☐ NOT REQUIRED

8. Proposed Grant Title

9. Location of Proposed Project (include county)

10. Site Locations Number ATTACH ADDITIONAL SHEETS

11. a. Will any member of the Board of Directors/Trustees receive any direct or indirect personal or monetary gain from the funding of this grant? ☐ YES ☐ NO

b. Does any member of the Board of Directors/Trustees serve on any board, council commission, committee or Task Force which has regulatory or advising influence on the funding program? ☐ YES ☐ NO

_____ MEMBER _____ BOARD, COUNCIL, ETC.

11c. Type of payment plan preferred ☐ Cost-Reimbursement ☐ Advance Payment

11d. Location where payments should be sent

12. Type of Agency (check one)
☐ PRIVATE NON-PROFIT ☐ GOVERNMENT ☐ HOSPITAL
☐ PRIVATE PROFIT ☐ OTHER (Specify) _____

13. Does the Agency Meet the following Licensure Requirements?

	YES	NO	PENDING	N/A
FOR FACILITY	☐	☐	☐	☐
FOR SERVICES	☐	☐	☐	☐
FOR PERSONNEL	☐	☐	☐	☐

14. Agency Fiscal Year End

15. Agency Accounting System:
☐ Cash Basis ☐ Other (Specify)
☐ Accrual Basis

16. Type of Request
☐ NEW ☐ RENEWAL OF GRANT NO.: _____
☐ MULTI YEAR GRANT ☐ MODIFICATION TO GRANT NO.:
YEAR: ☐ 1 ☐ 2 ☐ 3 _____

16a. Budget Period Mo./Day/Yr.
From: _____ Through:
b. Project Period Mo./Day/Yr.
From: Through:

17. Is political subdivision covered by NJ Civil Service Merit System? ☐ YES ☐ NO

18. Affirmative Action Plan ☐ YES ☐ NO

19. If grant is awarded, will funds be used to replace other funds which would be available in absence of award? ☐ YES ☐ NO

COST OF PROJECT

20a. Total Funds Needed	1	b. Funds Requested from State	2	c. Funds From Other Sources	3

21a. Name of NJDHSS Representative Regarding Application

21b. Program (Granting Agency)

22. CERTIFICATION – The applicant certifies that to the best of his/her knowledge and belief all data supplied in this application and attachments are true and correct, the document has been duly authorized by the governing body of the applicant and further understands and agrees that any grant received as a result of this application shall be subject to the grant conditions, and other policies, regulations and rules issued by the New Jersey Department of Health and Senior Services which include provisions described in grant application instructions.

NAME AND TITLE OF APPLICANT (Print)	SIGNATURE OF APPLICANT	DATE OF APPLICATION

New Jersey Department of Health and Senior Services

APPLICATION FOR MINI-GRANT FUNDS
($25,000 OR LESS)

(Attach additional sheets if necessary.)

ASSESSMENT OF NEED(S) - List the need(s) that illustrate the reason for the project:

OBJECTIVE(S) OF PROJECT - List what will be done to alleviate "Needs" described above:

COST OF PROJECT - Indicate costs related to project: